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Medicaid 101: what you need to know about long term care options

By Erin M. Evers, Attorney at Law

Medicaid is a joint federal-state program created to assist individuals with limited income and assets in obtaining access to health care services. Medicaid coverage can also help qualified applicants age 65 and over who are disabled and in need of long term care with paying for residential care, assisted living, memory care, adult foster care, support in the home, in-home services, and nursing home care.

Who administers Medicaid?

In Oregon, the state's Department of Human Services (DHS) administers the Medicaid program. Depending on the situation, the applicant would apply for Medicaid through one of three divisions of DHS. Applicants whose primary need is for mental health services would apply for services through the Mental Health division. Applicants with developmental disabilities would apply for services through Developmental Disability Services. Applicants who are over the age of 65—or under 65 with blindness or other qualifying disability—would apply for services through the local office of the Seniors and People with Disabilities (SPD) division of DHS. Be aware that in some areas, the local Area Agency on Aging (AAA) makes the Medicaid eligibility determinations. For example, the county Senior and Disabled Services department handles applications in Lane County and the county Aging and Disability Services Division handles applications in Multnomah County.

In 2009, the Oregon legislature created the Oregon Health Authority (OHA). Some responsibilities of DHS for administering Medicaid services are being transferred to OHA, but SPD is expected to retain the responsibility for Medicaid for long term care services. The system, rules, and terminology are all a bit convoluted. For example, adults who qualify for Medicaid coverage for long term care services are covered under the program OSIP-M (Oregon Supplemental Income Program Medical). A useful glossary of terms and acronyms is available online at **www.dhs.state.or.us/spd/tools/glossary.htm#qpp**.

This article focuses on qualification for Medicaid services through Adult and Aging Services. The processes for qualification through Mental Health or Developmental Disabilities, while similar in some aspects, are entirely different in others.

Application process

To qualify for Medicaid, an individual must request services. This request can be as simple as a phone call to the intake worker of the day at the local SPD or AAA office. When timing is critical, a practitioner may prefer to file an application with the local SPD or AAA office and retain a file-stamped copy to document the date of the initial request. It is important to document the date of request because the effective date for starting benefits is the date of the request, as long as all eligibility requirements are met on that date. If the applicant has not met the eligibility criteria on the date

Continued on page 2

In this issue...

Medicaid 101

Continued from page 1

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of request, the effective date for benefits is the first day that all eligibility requirements are met. For applicants who are eligible for medical benefits because of their eligibility for long term care services, the effective date is the effective date of the eligibility for long-term care.

Preliminary qualification requirements

An applicant for Medicaid must provide a Social Security number and be a resident of Oregon and a citizen of the United States or a qualifying noncitizen. OAR 461-120-0125. Interestingly, there is no minimum residency period, but there must be an intent to remain in Oregon, and an individual who is adjudged to be legally incompetent is per se not capable of indicating an intent one way or the other for this purpose. A physician, psychiatrist, or psychologist can also document that the applicant is not capable of indicating intent. The rules are vague as to who may indicate intent for an incompetent adult, except the rules do provide that an incompetent adult intends to remain in the state in which placement is made if made by an agency of the same state (i.e., if DHS places the incompetent adult in Oregon, that placement presumptively determines residency in Oregon for purposes of Medicaid qualification).

In addition, the applicant must assign medical reimbursement rights to DHS and actively pursue collection of any asset or claim to which the applicant has a legal right. This includes applying for any and all benefits available and attempting to secure legal counsel on a contingency-fee basis to pursue legal remedies—but there is no need to pursue loans or secure SSI benefits. Nor is there a duty to pursue any asset if circumstances exist beyond the applicant's ability to control them.

To qualify for Medicaid long term care services, an applicant must have three substantive areas of need—health, income, and resource—and the meat of the application process is to establish need in these three areas.

Health need

Medicaid benefits are available only to those applicants who have a qualifying health need. In essence, Medicaid evaluates an applicant and assigns him or her a service priority level from one to 18, with one being the highest level of need and 18 the lowest. Medicaid refers to these priority levels as service needs. Applicants with demonstrated need in service priority levels one through 13 who also meet the income and asset tests are eligible for Medicaid assistance for long term care services. Applicants with service priority levels 14 to 18 do not currently qualify for Medicaid, regardless of income and assets. The criteria for qualifying at each service priority level can be found online at www.dhs.state.or.us/policy/spd/rules/411_015.pdf (Refer specifically to OAR 411-015-0010, but read OAR chapter 411, section 015, in its entirety for definitions, explanations, and an understanding of the framework.)

In the evaluation of an applicant's service priority level, Medicaid looks at the applicant's ability to complete various activities of daily living. Activities of daily living (ADLs) are those personal functional activities that are essential for an individual's health and safety. OAR 411-015-0006. ADLs include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination/toileting, and cognition/behavior. ADLs are rated as independent, some assistance, or full assistance. The more assistance required to survive, the higher the priority level assigned. Thus, an applicant who requires a structured environment but is otherwise independent will be assigned a much lower service priority level than an applicant who has cognition/behavioral limitations.

DHS and AAA caseworkers are trained to evaluate an applicant's ability to meet the required ADLs using the SPD 360 form. During the application process, the case manager will evaluate the level of assistance required by meeting with the applicant and asking a series of personal questions. It is important that the applicant be forthcoming and honest in answering. If the applicant is not a good historian, it is critical to have the caseworker interview an advocate who has accurate knowledge about the applicant's ability to function independently, because the determination of eligibility may depend on the answers.

Income need

For an applicant in long term care situations, Oregon Medicaid rules require that his or her monthly income be no more than 300% of the full SSI income standard. In 2011, that amount is $2,022. This income limitation

Continued on page 3

Medicaid 101

Continued from page 2

generally changes every January 1, based on the Social Security cost of living adjustment (COLA). An applicant's monthly income includes earned and unearned income such as Social Security payments, pensions, some Veterans benefits, workers compensation, annuity payments, wages, self-employment income, interest earned, dividends, and other regularly recurring payments.

Income falls into four different categories: available, unavailable, countable, and excluded. OAR 461-001-0000 and 461-140-0010. Available sources of income are countable for the income determination while unavailable and excluded sources of income do not count for the income determination.

Examples of sources of unavailable income include situations where the source of income has been illegally withheld from the applicant, or the income source is received by the applicant but intended and used for the care of someone not in the applicant's financial group. Sources of unavailable, hence excluded, income includes the portion of a jointly owned source of income that is legally attributable to the joint owner (e.g., contractual payments received by an applicant and his spouse jointly would be apportioned between the applicant and spouse.) When calculating an applicant's income, exclude income sources legally received by the applicant's spouse. Count only the applicant's sources of income and the applicant's share of joint-source income. Do not make the mistake of simply dividing the couple's household income in two and assuming that this is the applicant's income. Count only the income that is legally available to the applicant. See OAR 461-140-0040 for determining availability of the applicant's income.

Income is considered available on the earlier of the date the payment is received or the date that the applicant has a legal right to the payment and the legal ability to make it available (but see exceptions in OAR 461-140-0040.) Income usually paid on a regular payment schedule is considered available on the regular payment date. Income withheld or diverted at the request of an individual is considered available on the date the income would have been paid without the withholding or diversion.

The amount of the payment considered as income is the amount of the gross payment before deductions (i.e., federal or state income tax withholding, deductions for medical insurance premiums, garnishments). Unless excluded under the rules, the applicant's income is counted toward the income cap of $2,022.

If an applicant's countable income exceeds the $2,022 limit, then the applicant (or someone with legal authority to act for the applicant) can establish a Medicaid income cap trust and transfer the applicant's income to the trust to allow an otherwise qualified applicant to become eligible for Medicaid assistance. If no one has authority to establish the income cap trust, a court order in a protective proceeding may be needed. DHS has a form of an acceptable income cap trust online at www.dhs.state.or.us/spd/tools/program/osip/incap.pdf. When the trust is created, the Medicaid applicant (who is the grantor of the trust) assigns all of his or her income to the trust. Since the applicant no longer controls the income, he or she is treated as being under the income limit for eligibility purposes.

The trustee named in the income cap trust manages the income and makes the payments authorized by DHS through a budgeting process. The budget is drafted in accordance with Medicaid rules and allows for a small trustee's fee (up to $50/month), a personal needs allowance for the Medicaid recipient (who is the lifetime beneficiary), and other applicable deductions listed in OAR 461-145-0540(9)(c). The remaining balance is the Medicaid recipient's liability for his or her care. The case manager will generate a new financial planning sheet to update the budget when there is a change in the amount of the Medicaid recipient's income or in the amounts of the deductions.

When the beneficiary dies, the trustee is required to remit any remaining funds to the state to reimburse it for services rendered.

Resource need

The Medicaid rules use the term assets to include both sources of income and resources. Resources are what lay people would generally call assets: bank account balances, investment account value, retirement account value, home equity, vehicles, personal property, principal outstanding on a contract, etc. For Medicaid purposes, a qualifying applicant is limited to $2,000 of countable resources. If the applicant is married, the resources that belong to either spouse or to both spouses are considered available, and the non-applicant or "community spouse" is limited to the amount of the countable resources in the community spouse resource allowance, which is described below.

Resources that are unavailable or excluded are not counted. If a source of income is counted as income it is not also included in the resource test in the same month; it is either a resource or income but not both. Beware, however, because income not spent in the month received will convert to an available resource on the first day of the following month and could affect the applicant's ability to continue to qualify for Medicaid if the resource limit is exceeded.

Available resources include those that the applicant (or spouse) could turn into cash. The applicant's (and spouse's) interests in jointly held liquid assets are considered available to the applicant. Excluded resources include personal belongings; medical and adaptive equipment; an irrevocable, non-assignable prepaid burial or funeral contract or a

Continued on page 4

Medicaid 101

Continued from page 3

To qualify for Medicaid long term care services, an applicant must have three substantive areas of need—health, income, and resource.

bank account with a balance up to $1,500 earmarked for burial or funeral purposes for each spouse; one vehicle if used to transport the applicant or spouse; and—with some limitations noted below—the applicant's (or spouse's) principal residence (OAR 461-145-0220, temporarily effective 1/1/11 through 6/30/11); income-producing real property, property that is essential to the applicant's self-support, and the community spouse resource allowance. OAR 461-160-0580.

Home: The value of the applicant's principal residence is excluded if any of thefollowing conditions apply.

1) The applicant's minor or disabled child occupies the home.
2) The applicant's spouse occupies the home.
3) The equity value is less than $506,000 and the applicant occupies the home.
4) The equity value is less than $506,000 and the home is listed for sale at a reasonable price and there is a good faith effort to sell the home. OAR 461-145-0220 and OAR 461-145-0420.
5) The equity value of the residence is more than $506,000, but the applicant is unable to legally convert the equity value in the home to cash.

Non-income-producing real property limitations: If the applicant (or spouse) owns non-income-producing real property, the equity value of the real property can be excluded for up to nine months if it is listed for sale at a reasonable price and there is a good-faith effort to sell the property. If there is no good faith effort to sell, then the equity value will be counted. OAR 461-120-0330. If the property is not sold within nine months, the asset is included as a resource unless the failure to sell is for reasons beyond the reasonable control of the applicant (or spouse). OAR 461-145-0420.

Income-producing real property: If the property produces an annual countable income of at least six percent of its equity value, the value of the property is excluded up to a value of $6,000. The entire equity value can be excluded if the property produces income that is essential to the applicant's self-support. OAR 461-145-0250(2)(c).

Community spouse resource allowance: A person who is legally married to an applicant and who is not institutionalized himself or herself is allowed to keep a community spouse resource allowance (CSRA). OAR 461-160-0580. The first step in determining the amount of the CSRA is calculation of the combined value of the couple's countable resources (regardless of legal title), as of the date when the applicant began his or her most recent continuous period of long term care (in-home services provided by someone other than the spouse or care in a hospital, nursing facility, or community-based care facility) without a break of 30 days or more. This is sometimes called the "snapshot date." Excluded resources (the home, one vehicle for transportation, burial funds, etc.) are not counted.

In 2011, the community spouse is allowed a resource allowance (CSRA) equal to the largest of the following:

1) a minimum value of $21,912
2) half of the couple's countable resources up to a maximum of $109,560
3) a court-ordered resource allowance for the community spouse that generates income beyond what is available from the applicant's income in order to pay a court-approved monthly maintenance needs allowance (MMNA)[1]
4) an amount which if invested would raise the community spouse income to the MMNA when the amount available from the applicant's income is insufficient to do so. DHS can waive the requirement that income be shifted before resources if the department determines that the resulting resource allowance would create an undue hardship on the community spouse. OAR 461-160-0580(4).

The applicant will be financially eligible for Medicaid assistance when the couple's current combined countable resources, minus the amount of the CSRA, is below the applicant's resource limit of $2,000 and the applicant's countable income is below the income limit of $2,022 per month (or a Medicaid income cap trust has been established for the applicant).

Your applicant has qualified, now what?

Once DHS approves the application, the resources for the CSRA must be transferred to the community spouse within 90 days of

Continued on page 5

Medicaid 101

Continued from page 4

qualification. This transfer period may be extended by DHS based on a showing of good cause. The resources are excluded during the transfer period. After the transfer period, any resources owned by the applicant but not transferred to the community spouse will be counted as resources available to the applicant/Medicaid recipient and these resources will be used to determine the recipient's ongoing eligibility. OAR 461-160-0580.

After qualification for Medicaid, the recipient's countable income is used to help pay for his or her care costs, after deductions allowed by OAR 461-160-0620:

1) a personal needs allowance of $30 per month if the person is receiving long term care services in a nursing facility ($90 a month if the person is eligible for VA benefits based on unreimbursed medical expenses if the VA benefit is reduced to $90) or $152 a month if the person is living in a community-based care facility (adult foster-care home, residential care facility, or assisted living facility), or the OSIP maintenance standard of $675.70 a month if the person is receiving in-home services
2) the amount of the community spouse monthly income allowance, if any
3) the amount of a dependent income allowance, if any
4) costs of maintaining a home if a physician documents that the applicant is likely to return home within six months. OAR 461-160-0630
5) allowable medical deductions for costs not covered under the state Medicaid plan, including health insurance premiums of the community spouse and dependents, if any. The premiums for Medicare Part B (usually automatically deducted from Social Security benefits), Medicare supplement policies, Medicare Advantage plans, and Part D prescription drug plans are allowed as medical expenses deductions. Allowed medical costs also include medical and dental care, prescription drugs and over-the-counter drugs prescribed by a licensed practitioner, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses. OAR 461-160-0055.

After qualifying for state services, the Medicaid recipient or his or her representative will want to maintain an ongoing dialogue with the case manager to communicate any changes in income or deductions (e.g., projected medical expenses to allow necessary services which are not paid by Medicaid).

Disqualifying transfers

Be very careful in counseling clients about transfers of assets. The Medicaid rules provide for harsh penalties for gifts and transfers for less than fair market value, unless the gifts or transfers are specifically permitted by the Medicaid rules.

The transfer rules are very complex. As noted above, both resources and income are considered assets under the Medicaid rules. Therefore, the rules regarding transfers of assets apply to both transfers of income and transfers of resources. The Medicaid application asks for information about gifts and transfers made by the applicant (or spouse) within the five years (60 months) preceding the date of application, based on OAR 461-140-0210(5). A gift or transfer for less than fair market value made within this five-year "look back period" will disqualify the applicant from receiving Medicaid assistance for long term care for a period of time. The disqualification period is equal to the uncompensated value of the asset that was transferred, divided by the then-in-use private pay rate (for months beginning on or after October 1, 2010, the figure is $7,663). OAR 461-140-0296. For example, an applicant who transferred a resource worth $76,663 would have a disqualification period of ten months. The disqualification period will begin on the later of the date of the transfer or the date when the applicant has applied for Medicaid and met the rest of the Medicaid eligibility requirements. Using the example above, the applicant would be ineligible for Medicaid assistance for a period of ten months from the date when he or she would otherwise be eligible, even if the transfer of assets took place four years before the date of application.

Transfers that do not result in a period of ineligibility

Medicaid rules allow an applicant (or spouse) to make certain transfers, which are listed in OAR 461-140-0242(3). The non-disqualifying transfers include transfers of income to an income cap trust, discussed above; transfers of resources to a spouse; transfers of resources to a trust for the sole benefit of the applicant's disabled (as defined in the criteria used for Social Security disability and SSI benefits) son or daughter; and transfers of the applicant's home to a son or daughter who lived in the home with the applicant for at least two years while providing care that meets the criteria in the rules.

A basic, relatively uncomplicated example

A and B are married. A has dementia. A is incapable of self-care, needs reminders to eat, bathe, dress, and take medications. A does not drive, shop, plan meals, or participate in financial management. B is no longer capable of caring for A in the home and places A in a memory care facility that has a Medicaid contract.

The couple's assets consist of a jointly owned home, one car in B's name only, $120,000 in bank accounts and certificates of deposit, of which $2,000 is in A's name and $118,000 is in B's name because the family has recently done some self-help planning in anticipation of A's needs. A's gross monthly income of $2,600 is comprised of pensions

Continued on page 6

Medicaid 101

Continued from page 5

and Social Security benefits. B's gross monthly income of $1,200 is comprised of pensions and Social Security benefits.

The first step is to identify your client. You should not attempt to represent both a Medicaid applicant and his or her spouse unless both spouses consent following the disclosure of the potential conflict of interest. In this example, assume that B (the community spouse) is consulting you.

To get an idea about whether A is likely to fit the Medicaid program's service priority levels, refer to OAR chapter 411, section 015. Due to A's cognitive deficits and need for assistance in the activities of daily living, it appears that A will be within priority service levels one through 13 and therefore qualify for benefits based on a demonstrated health need.

Next, analyze the income of the Medicaid applicant (A) and the community spouse (B). A's income is above the current limit of $2,022. An income cap trust will be needed in order for A to qualify for Medicaid assistance. Find out if B has authority to establish the income cap trust for A.

B's income is less than the standard community spouse monthly maintenance needs allowance of $1,822 per month, so B can receive a portion of A's income each month to bring B's income up to the standard. B may be entitled to more than the standard amount, depending on B's shelter expenses.

Finally, analyze the couple's resources. One approach is to prepare a spreadsheet with a section for excluded assets (the home and car) and a section for countable resources (the bank accounts). Note that even though most of the bank accounts and certificates of deposit are in B's name only, for Medicaid qualification purposes, the assets are assumed to be available to both spouses. The countable resources at the beginning of A's continuous period of care totaled $120,000. B's community spouse resource allowance is half of that amount, or $60,000. The remaining $60,000 will have to be spent down to A's resource limit of $2,000 before A will qualify for Medicaid assistance.

The amount that has to be spent down can be used to pay for A's care, for B's living expenses, payment of debts and bills of either or both spouses, purchase of excluded resources (such as irrevocable burial plans for both A and B), and maintenance or improvement of excluded resources (for example, repairing the roof of the home where B lives or replacing the tires on the car).

Consider whether there have been any transfers (as part of the family's self-help planning or otherwise) within the past five years that may have caused a disqualification period. Counsel the client on the rules, his or her options, and your recommendations for timing the application and pre-application preparation.

Resources for elder law practitioners

The Medicaid laws and rules provide a constantly changing landscape. DHS promulgates new rules several times a year and case law develops to interpret state application of federal mandates.

Available resources include:

- United States Code, Title 42, Chapter 7
- Oregon Revised Statutes
- Chapter 461 of Oregon Administrative Rules
- Elder Law, Chapter 8—available from the Oregon State Bar BarBooks™
- OSB CLE materials, especially from the annual Elder Law CLE seminars
- DHS rules at www.dhs.state.or.us/policy/selfsufficiency/ar_search.htm
- DHS worker guides at www.dhs.state.or.us/spd/tools/program/osip/index.htm
- The Elder Law Section's newsletter ■

Footnote

1. As defined in OAR 461-160-0620, MMNA is the monthly maintenance needs allowance granted to the community spouse. It represents a minimum income that can be allocated to the community spouse if her or his income is below the MMNA as calculated under the rules. The standard allowance of $1,822 includes a basic shelter allowance of $547. If actual shelter expenses exceed the $547 allowance, the excess shelter expenses can be added to the standard MMNA of $1,822 up to a maximum needs allowance of $2,739. Allowable shelter costs include rent or the home mortgage payment plus property taxes and insurance for the community spouse's principal residence. After calculating the MMNA, compare the MMNA to the community spouse's countable income. If the community spouse's monthly maintenance needs allowance is greater than the community spouse's countable income, income of the Medicaid recipient can be paid to the community spouse to make up the difference. If insufficient income is available from the Medicaid recipient, OAR 461-160-0580(2)(c)(D) allows the amount of the CSRA to be increased in order to generate additional income for the community spouse. In some circumstances, it is possible to demonstrate to the case manager that there are exceptional circumstances which would result in significant financial distress on the community spouse unless the income/resources are shifted or to obtain a spousal support order through the domestic relations court.

Strategies for managing the cost of long term care

By Carole Barkley, Elder Law Newsletter Editor

Ask anyone where she or he would like to live in old age, and the answer will most likely be "at home." A nursing home is no one's first choice, but honoring the desire of an elder to remain at home can be a costly proposition. There are ways, however, to mitigate the expense.

When the need for care is temporary, going through a private caregiver agency may be the best solution and can be quite cost-effective. In a typical scenario, a patient is discharged quickly from the hospital following surgery or an illness, but needs two to three weeks of recuperation. When the patient is not capable of self-care or the person with whom they live is not capable of providing the needed care, the discharge coordinator at the hospital will help find the best solution. Medicare will pay for a few weeks of rehabilitative care in a nursing facility following a hospitalization. If the patient returns home, home health agencies can follow up after a hospitalization to make sure the doctor's care plan is being implemented. Home health agency fees range from $35 to $50 per hour. Medicare will pay for a home health agency as long as the service is prescribed by the doctor. If it is a hospice situation—in which the elder is likely to die within six months or so—Medicare coverage is also available. For more information, see Peggy Toole's article in the Winter 2005 *Elder Law Newsletter*: "Medicare provides some benefits for post-hospitalization care."

When the need for care is long term, however, the picture is different. According to a survey by Northwestern Long Term Care Insurance Company, the average cost of home health care through an Oregon agency is $26 an hour. At that rate, hiring a team of caregivers around the clock would cost almost $19,000 a month—clearly beyond the resources of all but the wealthy.

Kathy Shannon of Legacy Caregivers points out, however, that cost is dependent on what a person needs, and many elders do not require skilled nursing services. If round-the-clock nursing care is not required, the cost will be less. Of course, family members may be available and willing to cover some of the hours when caregiving is needed.

Medicaid and Medicare

Elders who qualify for Medicaid have access to programs that make it possible for many to remain at home, and Medicaid beneficiaries may also be eligible for the state's special needs program. For detailed discussions of Medicaid programs see "An introduction to long term care and Medicaid in Oregon" by Penny Davis in the Winter 2005 issue of *Elder Law Newsletter* and Kit Morgan's article "What Medicaid covers if the beneficiary is at home" in the April 2008 issue.

Oregon's Medicaid waiver home and community-based services program will pay family members for providing in-home care to an elder. Details can be found in "Paying family members for in-home care," an article by Leslie Harris in the Winter 2005 issue of *Elder Law Newsletter.*

For middle-class families, the financial burden of long term care can be a challenge. Medicare does not pay for long term care. Long term care insurance policies sold in Oregon are legally required to cover in-home care, but many people do not have such policies. Most families find themselves tapping personal resources—e.g., savings, investments, annuities, reverse mortgages—to cover care costs.

Hiring a private caregiver

Hiring a caregiver directly rather than through an agency is one way to reduce costs. For example, a non-agency non-medical person to provide housekeeping, cooking, and companionship will charge $10 to $15 an hour.

Although hiring a private caregiver can reduce the hourly cost, families must be made aware that this involves more legwork on their part—and the assumption of greater risk. When hiring help on their own, families have to find suitable candidates, assess their skills and personalities, conduct background investigations, verify citizenship, check references, and assume responsibility for monitoring job performance. The employer is also required to pay employment taxes and file the required tax forms. For a fuller discussion of employer responsibilities, see "Employment laws apply to in-home care providers," an article by Dan Grinfas in the Winter 2003 *Elder Law Newsletter.*

Continued on page 8

Managing care costs

Continued from page 7

Clients who are faced with the effort and expense of hiring a caregiver may be tempted to pay such a person "under the table." This attempt to skirt employer regulations can backfire. For example, an unsatisfactory employee who is fired may apply for unemployment benefits and the subsequent investigation will create legal problems.

Hiring a private caregiver is getting harder and harder to do, according to both Legacy's Kathy Shannon and Rick Davison of Adult Living Alternatives. There are good trained caregivers who want the jobs and would rather work for a private employer than earn minimum wage at a nursing home—but finding them can be a challenge.

Family doctors are unlikely to be helpful in this situation, and there aren't many caregiver training and referral services. A major resource, Legacy Health's caregiver program, is scheduled to be shut down at the end of June, and will issue its last list of trained and screened caregivers this month.

Davison says some families look to the information and referral person at their local senior center for help in finding a caregiver. People looking for a caregiver position often contact senior centers, and the centers do keep lists of these people and their phone numbers—but they do not screen them in any way. Davison stresses the need for thorough background checks, references, and interviews.

Others may ask their churches or synagogues for help in locating a caregiver. Again, any candidates found this way must still be evaluated by the person doing the hiring.

Shared housing

If housekeeping, cooking, and home maintenance services are all that is needed, an alternative to hiring an employee is the elder sharing his or her home with someone in exchange for the performance of agreed-upon chores. For this to work, it is important that both parties understand that this is not an employer-employee relationship, and the expectations of both parties must be clearly spelled out. Ecumenical Ministries of Oregon operates a shared-housing referral program that screens participants and guides them through the process of establishing a workable agreement. For information about this program, see "Shared housing may be the right solution for an elder" by Sylvia Callaway in the April 2009 *Elder Law Newsletter*.

Adult day care

A fair number of adult daycare centers are available around the state and can be a valuable resource, particularly when an elder has dementia or is unable to safely navigate his home when alone.

The cost of this service generally runs between $50 and $100 for a nine-hour day. The cost of running such a facility is driven by the level of personal care, food, therapeutic and recreational activities, and supervision provided. Davison notes that for-profit daycare facilities have a high failure rate, because entrepreneurs may underestimate the financial demands of providing adequate care. He advises families to look for centers run by nonprofits and healthcare providers. Providence ElderPlace, for example, includes adult daycare in its services. An overview of the program can be found in the April 2010 *Elder Law Newsletter*: "Providence ElderPlace provides complete care system for elders."

Adult foster care

If an elder cannot stay safely in his or her own home, an adult foster care home may be the answer. Foster homes are filling the gap between assisted living facilities that offer only minimal medical care, and nursing homes that provide high-level care for seriously impaired individuals. An adult foster home will cost about $4,000 a month—considerably less than the $7,500 fee charged by a typical nursing home.

Foster homes are generally small and have a homey atmosphere and serve home-cooked meals. Many are operated by recent immigrants, some of whom have had medical training in their native countries. The state regularly inspects foster homes.

Professional advice

If a client is not sure what level of care needs to be provided for an elder, a professional case manager can help evaluate the situation to determine exactly what sort of help is needed. These individuals may be registered nurses or licensed social workers and generally charge between $50 and $100 an hour.

Referral services such as Adult Living Alternatives can provide information on care facilities and adult foster homes. Their fees are typically paid by the facilities and not by the client.

Finding a balance between careful stewardship of resources and adequate care for elders can be a daunting process. Families often turn to elder law attorneys for advice. Familiarize yourself with community resources—daycare facilities, foster care homes, home health services, case managers, etc.—and your clients will benefit. ■

State regulates the way nursing facilities charge fees

By Richard H. Mills, Department of Human Services OPAR Policy Unit

At the recent unCLE seminar, I was asked if there are any restrictions on a nursing facility that requires clients and/or family to sign a contract stating the client will pay privately for a certain period of time before receiving Medicaid. Renee Shearer, RN, of the Department of Human Services' Nursing Facility Licensing and Quality of Care program provides the following guidance.

OAR 411-085-0320 Residents' Rights: Charges and Rates

(1) ADMISSION. The facility must provide written and oral notice before or at the time of admission to each resident specifying:
- (a) The base daily rate, or Medicaid rate and, as soon as known, amount of resident liability, as applicable; services provided for that rate, and other charges that might reasonably be expected, including but not limited to medical supplies, pharmaceuticals, incontinence care, feeding, bedhold daily rate, and laundry;
- (b) Whether the facility accepts Medicaid reimbursement:
  - (A) If the facility accepts Medicaid reimbursement, the notice must include a description of the Medicaid eligibility requirements and who to contact to apply for Medicaid assistance;
  - (B) If the facility does not accept Medicaid, the notice must include the facility's policy regarding residents who exhaust their private resources and become eligible for Medicaid;
  - (C) Nothing in this section will be construed to permit discrimination based on payment source; and
- (c) Alternative forms of transportation available to the resident for routine and emergency transportation, including information on possible cost and how to access such service(s).

OAR 411-070-0010 Conditions for Payment

(2) CIVIL RIGHTS, MEDICAID DISCRIMINATION.
- (a) The facility must meet the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- (b) The facility must not discriminate based on source of payment. The facility must not have different standards of transfer or discharge for Medicaid residents except as required to comply with this rule.
- (c) The facility must accept Medicaid payment as payment in full. The facility must not require, solicit, or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a "responsible party."
- (d) No applicant may be denied admission to a facility solely because no family member, relative, or friend is willing to accept personal financial liability for any of the facility's charges.
- (e) The facility may not request or require a resident, relative, or "responsible party" to waive or forgo any rights or remedies provided under state or federal law, rule, or regulation.

If someone believes that a nursing facility is violating the rules, a complaint can be referred to the Office of The Long Term Care Ombudsman at 800.522.2602

or to: Renee Shearer, RN
Nursing Facility Program
Oregon Dept of Human Services, Licensing and Quality of Care
voice: 503.945.5923; fax: 503.378. 8966
500 Summer St NE E13; Salem, OR 97301
Renee.M.Shearer@state.or.us

The rules cited above are specific to nursing facilities, but not to any other kind of facility that may accept Medicaid, including assisted living facilities, memory care facilities, and residential care facilities.

According to Ms. Shearer, community-based long term care facilities have their origins in the social model of care, a difference from nursing facilities. A feature of community-based care is variable services and policies within a facility type. For this reason, she suggests, it may be most helpful for consumers to bring concerns about resident rights on a case-by-case basis to either the Long Term Care Ombudsman or the DHS department that licenses such facilities for issue analysis and advocacy. ■

Coming soon to your inbox: the elder guardianship mediation survey

By Jennifer L. Wright, Associate Professor of Law, University of St. Thomas School of Law

You will soon receive an invitation to participate in an online survey about your experiences (or lack thereof) with respect to elder guardianship mediation. Why should you take a few minutes of your valuable time to complete this survey? Here are a few reasons that may interest you.

1. It will help me.

Some of you know me well. I have been an elder law attorney since 1988. From 1988 until 2003, I practiced elder law in Oregon, working first for LASO (at that time, OLS) and then as the director of the Willamette University College of Law's clinical program. I served for several years on the Executive Committee of the OSB Elder Law section, including stints as secretary, vice-chair, and chair. In 2003, I moved to Minnesota to begin an elder law clinical program at the University of St. Thomas School of Law. Since then, I have been more and more drawn to the potential benefits and risks of elder law mediation to resolve many of the disputes that would otherwise end up in guardianship proceedings. Both my scholarly interests and our cases in the St. Thomas elder law clinic have led me in this direction. I want to make a useful contribution in this field, and I need your help.

2. It will help elders.

There is growing interest in the field of elder law mediation among elder law attorneys and advocates, particularly as a possible alternative to formal guardianship/conservatorship proceedings. Many advocates for the elderly perceive a need to resolve disputes involving elders' health care, personal assistance needs, finances, and living situation without necessarily involving courts. Some of the advantages offered by mediation are especially important to elders: involving the full range of interested parties, preserving and improving communications and family connections, preserving elders' participation, autonomy, and voice regarding their own lives, seeking creative resolutions tailored to the specific situation and needs of the elder, and resolving pressing problems more quickly and affordably than through the court system.

There are also serious concerns that can arise with elder law mediation, including concerns about the ability of elders to fully participate in the mediation process, concerns about mediators' lack of familiarity with Medicaid consequences of decisions about finances or assets, concerns related to the vulnerable adult protection system, and the need to protect elders from maltreatment, abuse, or financial exploitation.

With the rapidly rising numbers of impaired elders, and the shrinking capacity of the civil courts, it is inevitable that more and more disputes about elders' lives will be resolved outside formal guardianship/conservatorship proceedings. There is a need to develop standards and resources for elder law mediation to protect the rights and the well- being of elders, and to inform and encourage the public about the availability and potential benefits of well-conducted elder law mediation. I hope to use the results of this survey, which is being distributed to elder law and ADR practitioners in several states, to provide useful input on how to make guardianship mediation in general work for the benefit of elders.

3. It will help inform policy in Minnesota.

I am working with local elder law attorneys, mediators, judges, long term care providers, and other elder advocates to try to improve the quality and availability of elder law mediation in Minnesota. Minnesota has not been a leader in this area and has a lot to learn from the experiences of practitioners in other states. This is a strategic moment here in Minnesota, and your contribution can make a big difference.

4. It may be helpful in informing policy in Oregon.

I will be making the survey results, broken down by state, available to the leaders of the participating sections. This information may prove very useful in determining whether there are policy changes that might make mediation a more consistently useful tool in resolving disputes involving elders' care and decision making in Oregon.

I hope that one or more of these reasons will appeal to you enough to motivate you to take just a few minutes of time to complete the online survey. Look for an email with a link to the survey in your inbox in the next week or two. I look forward to your response. ■

Questions about the survey should be addressed to Jennifer L. Wright at jlwright1@stthomas.edu or 651.962.4952.

New rule on garnishments of accounts that include federal benefit payments

By Michelle Druce, Attorney at Law

Michelle Druce is Compliance Counsel for Aequitas Capital Management. She serves on the Executive Committee of the Business Law Section of the Oregon State Bar.

On February 23, 2011, the Department of the Treasury, Fiscal Service, Social Security Administration, Department of Veterans Affairs, Railroad Retirement Board, and Office of Personnel Management issued an interim final rule with request for public comment regarding garnishment of accounts containing Federal benefit payments. A new part 212 was added to Title 31 of the Code of Federal Regulations.

The interim final rule was effective May 1, 2011. Comments are due by May 24, 2011.

The rule establishes procedures that financial institutions must follow when they receive a garnishment order against an account holder who receives certain types of federal benefit payments by direct deposit. The interim rule does not apply to payments made by check.

The rule requires financial institutions that receive such a garnishment order to determine the sum of the federal benefit payments deposited to the account during a two-month period, and to ensure that the account holder has access to an amount equal to that sum or to the current balance of the account, whichever is lower.

The rule applies to all banks, savings associations, credit unions, or other entities chartered under federal or state law to engage in the business of banking.

Upon receipt of a garnishment order, an institution has two business days from the date of receipt to determine if the United States or a state child support enforcement agency has included in the order a *Notice of Right to Garnish Federal Benefits*. If the notice is included, the financial institution must follow its usual procedures for handling the order and the process and protection for federal benefit payments under the interim rule does not apply.

If the *Notice of Right to Garnish Federal Benefits* is not included in the order, the institution must review the account history during the two-month period prior to the receipt of the order. If during this "lookback period" one or more exempt payments were directly deposited to the account, the account holder must be given "full and customary" access to the lesser of the exempt payments in the account or the account balance as of the date of the account review, referred to as the "protected amount." The institution may not simply freeze the account. Also, the institution may not require an account holder to assert any right to a garnishment exemption or take any other action as a condition to gaining access to the protected amount.

The institution must calculate and establish the protected amount separately for each account in the name of an account holder to conduct distinct account reviews. A protected amount calculated and established by an institution will be conclusively considered to be exempt from garnishment under law.

If there are any funds in an account in excess of the protected amount, the institution must follow its otherwise customary procedures for handling garnishment orders, including the freezing of funds.

The institution shall not continually garnish amounts deposited or credited to the account following the date of account review, and shall take no action to freeze any funds subsequently deposited or credited, unless the institution is served with a new or different garnishment order.

The institution must send a notice to the account holder in the garnishment notice within three business days from the date of account review. The institution may issue one notice with information related to multiple accounts of an account holder. Section 212.7 sets out the notice content and other requirements. The notice must include:

1) notification that the institution received an order against the account holder
2) the date that the order was served
3) a succinct explanation of garnishment
4) the institution's requirement to protect and make available benefit payments directly deposited by a benefit agency within the last two months

Continued on page 12

New rule on garnishments

Continued from page 10

5) the protected account subject to the order
6) the institution's requirement pursuant to state law to freeze other (unprotected) funds in the account to satisfy the order and the amount frozen, if applicable
7) the amount of any garnishment fee charged
8) a list of the Federal benefit payments protected
9) the account holder's right to assert a further garnishment exemption for amounts above the protected amount
10) the account holder's right to consult an attorney or legal aid service in asserting against the creditor that initiated the order a further garnishment exemption for amounts above the protected amount
11) the name of the creditor, and (if available in the order) contact information.

The rule sets out protections during examination and pending review and protection when protecting or freezing funds, protection for providing additional information to an account holder, and protection for financial institutions from other potential liabilities if an institution complies in good faith.

The Department of the Treasury issued "Guidelines for Garnishment of Accounts Containing Federal Benefits," which can be found online at **www.fms.treas.gov/greenbook/guidelines_garnish0311.pdf.**

Starting on or about March 12, 2011, the Department of the Treasury, Financial Management Service began encoding Automated Clearing House (ACH) payments to enable receiving financial institutions to identify Federal benefit payments subject to the requirements of the rule. ■

Important elder law numbers

as of
January 1, 2011

Supplemental Security Income (SSI) Benefit Standards	
	Eligible individual.....$674/month
	Eligible couple.....$1,011/month
Medicaid (Oregon)	
	Long term care income cap.....$2,022/month
	Community spouse minimum resource standard..... $21,912
	Community spouse maximum resource standard.....$109,560
	Community spouse minimum and maximum monthly allowance standards.....$1,822/month; $2,739/month
	Excess shelter allowance..... Amount above $547/month
	Food stamp utility allowance used to figure excess shelter allowance.....$397/month
	Personal needs allowance in nursing home.....$30/month
	Personal needs allowance in community-based care.....$152/month
	Room & board rate for community-based care facilities..... $523.70/month
	OSIP maintenance standard for person receiving in-home services.....$675.70
	Average private pay rate for calculating ineligibility for applications made on or after October 1, 2008.....$7,663/month
Medicare	
	Part B premium for those enrolled in 2011..... $115.40/month*
	Part B deductible..... $162/year
	Part A hospital deductible per spell of illness.....$1,132
	Part D premium:.....Varies according to plan chosen
	Skilled nursing facility co-insurance for days 21-100.....$141.50/day

* For those enrolled in 2010, the premium is $110.50. For those enrolled in 2009, the premium is $96.50. For those enrolled prior to 2009, the premium is $96.40. Premiums are higher if annual income is more than $85,000 (single filer) or $170,000 (married couple filing jointly).

Resources for elder law attorneys

CLE seminars

Special Needs Trusts
OSB Seminar
June 10, 2011; 8:30 a.m.to 12:30 p.m.
Oregon Convention Center, Portland
www.osbar.org

Race, Class, and Gender: Their Impact on Working with Diverse Clients
June 10, 2011; 1:30 p.m. to 4:30 p.m.
Oregon Convention Center, Portland
www.osbar.org

Ethics of Email in Law Practice
OSB CLE Quick Call Seminar
June 10, 2011; 10:00 to 11:00 a.m.
Via telephone
www.osbar.org

2011 Estate and Trust Planning Update
OSB Quick Call Seminar
Day 1: June 14, 2011; 10:00 to 11:00 a.m.
Day 2: June 15, 2011; 10:00 to 11:00 a.m.
Via telephone
www.osbar.org

Estate Planning Fundamentals and Lab
Multnomah Bar Association Workshop
June 16, 2011; 2:00 to 5:30 p.m.
Kells Irish Pub; Portland
www.mbabar.org

Advanced Estate Planning
OSB Seminar
June 24, 2011; 9:00 a.m. to 5:00 p.m.
Oregon Convention Center, Portland
www.osbar.org

Advanced Elder Law Boot Camp
November 10–12, 2011
Seaport Hotel, Boston, MA
www.NAELA.org

NAELA-sponsored insurance programs

Administered by Association Health Programs, the NAELA-Sponsored Insurance Program provides access to insurance you need as an attorney and as a small business owner, including individual and group health insurance policies, long term care insurance, life insurance, professional liability, fiduciary, or other business insurance.
www.NAELA.org

Elder Law Section Web site

www.osbar.org/sections/elder/elderlaw.html

The Web site has useful links for elder law practitioners, past issues of *Elder Law Newsletter,* and current elder law numbers.

Elder Law Section electronic discussion list

All members of the Elder Law Section are automatically signed up on the list, but your participation is not mandatory.

How to use the discussion list

Send a message to all members of the Elder Law Section distribution list by addressing it to: **eldlaw@lists.osbar.org**. Replies are directed by default to the sender of the message *only*. If you wish to send a reply to the entire list, you must change the address to: **eldlaw@lists.osbar.org**—or you can choose "Reply to all."

Guidelines & Tips

- Include a subject line in messages to the list, for example, "lawyer referral needed" on the topic line.
- Try to avoid re-sending the entire message to which you are replying. Cut and paste the relevant parts when replying,
- Sign your messages with your full name, firm name, and appropriate contact information.
- In the interest of virus prevention, do not try to send graphics or attachments. ■